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ABSTRACT

This research review examines the selection, training, and efficacy of elderly peer counselors. The introduction explains why professionals alone will not be sufficient to deal with the growing mental health needs of older adults. The review goes on to provide a rationale for peer counseling with the elderly. Selection criteria of potential peer counselors and training considerations are discussed. Because much of the available literature addresses the use of programs operating through community mental health agencies, there is a discussion of research conducted on the extent and variety of these programs. The review also examines the use of elderly peer counselors working in groups, including a spouse support group and elderly peer facilitators educating their peers regarding stroke prevention and treatment. Issues of peer counselors used in an individual approach in nursing homes, individual blind peer counselors working with other elderly blind persons, and peer counselors working on a telephone hotline are addressed. Benefits experienced by the peer counselors themselves, including increased self-esteem gained by actively participating as helpers, are discussed. It is noted that there is a dearth of literature on elderly peer counselors and that the methodology of available studies is weak, making any conclusions drawn tentative at best. The review does suggest, however, that training elderly peer counselors to help meet the mental health needs of older adults is an efficient and cost effective alternative that warrants further exploration. (NB)

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THE USE OF PEER COUNSELORS IN THE TREATMENT AND SUPPORT OF THE ELDERLY

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THE USE OF PEER COUNSELORS IN THE TREATMENT AND SUPPORT OF THE ELDERLY

A Doctoral Research Paper

Presented to

the Faculty of Rosemead School of Psychology

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In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

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by

Jane Mary Harman

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ABSTRACT

THE USE OF PEER COUNSELORS IN THE TREATMENT AND SUPPORT OF THE ELDERLY

by

Jane Mary Harman

Research exploring the selection, training and efficacy of elderly peer counselors is reviewed. Due to the dearth of literature on this topic and the weak methodology of available studies, conclusions are at best tentative. Research suggests that training elderly peer counselors to help meet the mental health needs of this population is an efficient and cost effective alternative that requires further exploration. Elderly peer counselors appear to experience secondary gains of increased self-esteem by actively participating as helpers, and overall their counselees express satisfaction with the various programs. Considerations for future research are discussed.

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THE USE OF PEER COUNSELORS IN THE TREATMENT AND SUPPORT OF THE ELDERLY

Introduction

While the population of individuals over the age of 60 is steadily increasing, western society is still very youth-oriented; the result is an increasingly alienated and isolated group of aging citizens (France & McDowell, 1983). Aging is often accompanied by the rapid accretion of such potential crisis precipitants as serious illness; bereavement; substance abuse; and the loss of meaningful work-related activities, income, social roles, and status. The non-institutionalized elderly comprise 11% of the total population while accounting for 17% of the annual suicide rate, yet outpatient mental health services are significantly underutilized by the aged, accounting for only 4-5% of the outpatient population using community mental health services (Losee, Auerbach, & Parham, 1988).

Professionals alone will not be sufficient to deal with the growing mental health needs of older adults for a number of reasons: (a) professional resistance to treating the elderly, (b) high costs of professional services, (c) low Medicare reimbursement for mental health, (d) an increasingly underfunded mental health system, and (e) the resistance of older people to the use of mental health services (Bratter & Freeman, 1990). The concept of self-sufficiency was ingrained in the current elderly population by having suffered and

survived the Great Depression. As a result of this historical influence, this population subgroup is composed of people who frequently view rehabilitation assistance as welfare, and they express demoralized feelings and behavior when forced to seek rehabilitation services (Byers-Lang, 1984). The present atmosphere of fiscal austerity has led agencies to evaluate both the unique skills the older volunteer has to offer and the cost effectiveness of a volunteer program to service the elderly population (Hayes & Burke, 1987; Kirkpatrick & Patchner, 1987). Mental health counselors are faced with the challenge of providing services to an expanding population of elderly clients in the face of diminishing prospects for financial resources (Hayes & Burke, 1987).

Bratter (1986) and Bratter and Freeman, (1990) have noted that the counseling of seniors by seniors overcomes some of the major barriers that traditionally have stood in the way of mental health care for older people. Older peer counselors are reported to be empathic and respectful of their clients and tend not to have the negative attitudes toward working with the elderly that have been reported of some professionals. Paraprofessional counseling also removes the stigma associated with professional mental health services and helps to allay the common fear of the aged that they will be diagnosed as "crazy" and confined to an institution. Services can be provided at minimal cost to consumers. Bratter has contended that since peer counselors serve as positive role models for their clients, they can dispel the stereotypes of aging more easily than can younger counselors.

Peer counseling has been shown to be effective in assisting older adults to cope with life transitions such as retirement and widowhood (Scharlach, 1988). According to Bratter and Freeman (1990), the range of focus for groups also includes growth; sexuality; socialization; arts and crafts; self-esteem; drama; mental health problems from chronic mental illness to depression and loneliness; physical and medical problems from strokes to Alzheimer's and other forms of dementia, multiple sclerosis, arthritis, vision and hearing impairments; pain and stress; concerns of the frail, isolated, institutionalized, and homebound and their caregivers; problems of substance abuse; problems of the ethnic minorities; and issues related to gender.

Gatz, Hileman, and Amaral (1984) published a critical review which focused on selected issues relevant to programs in which older paraprofessionals work with their elderly peers. The purpose of this paper is to review the literature available on this topic since that time. Although the majority of the research reflects studies including individuals who were between the ages of 60 to 90 years old, this paper adresses information regarding peer counselors from the age of 49 to 98 years old.

First, this review provides a rationale for peer counseling with the elderly population. Selection criteria of potential peer counseling candidates and training considerations for this population are then discussed. Because much of the available literature in this area has addressed the use of programs operating through community mental health agencies using a variety of modalities, there is discussion of

research that has been conducted on the extent and variety of these programs. Second, the review presents the use of elderly peer counselors operating in a group modality, including a spouse support group and elderly peer facilitators educating their peers regarding stroke prevention and treatment. Third, the review addresses issues of peer counselors utilized in an individual approach in nursing homes, individual blind peer counselors working with other elderly blind, and peer counselors working on a telephone hotline. Fourth, the review discusses benefits experienced by the peer counselors themselves gained from participation in the various counseling programs. Finally, the review explores considerations for future research in a critique and summary of the available literature. Throughout the paper, an attempt has been made to address the effectiveness of volunteer programs for the elderly, together with an examination of advantages and disadvantages of the practice of peer counseling.

Rationale for Peer Counseling

Reissman (1990) maintained that help-receiving is problematic for any age group, as it tends to underline inadequacy. It casts the helpee in a dependent role made more asymmetrical because of the higher status of the professional helpgiver. An added detriment is that the helpee is automatically deprived of the increased sense of self-esteem which results from having been able to give help to others.

Peer counseling with the elderly is based upon the idea that with adequate training and supervision, an older person is capable of

providing the rudimentary counseling necessary to help other elderly individuals in maintaining their ability to cope by imparting the skills needed to deal with pressures associated with normal living (Kirkpatrick & Patchner, 1987). Self-help groups provide service systems that clients control by and for themselves. The afflicted deliver the service, and members often develop the program itself as a result of their own direct experiences and emerging needs (Lieberman & Bliwise, 1985; Petty & Cusack, 1989).

Peer counselors focus on helping the client develop the supports necessary for independent living, and special attention is given to enhancing the client's sense of self-worth and dignity. Four services provided by the peer advocate are (a) training, (b) referral, (c) supportive measures, and (d) companionship. These services are provided in a number of settings and can serve both preventative and therapeutic purposes (Kirkpatrick & Patchner, 1987).

Selection of Peer Counselors

In order to reduce attrition rates and contribute to the effectiveness of elderly peer counseling training programs, Hoffman (1983) developed screening criteria by which to evaluate potential applicants. The eight basic criteria included that the participants be (a) 60 years of age or older; in good physical health; (b) have experienced no serious depression in the preceding year; (c) have a desire to be trained and a willingness to attend all training sessions; and, (d) have a committment to work as a peer counselor a minimum of three hours a week for at least six months, in order to make the time spent for training cost effective for the agency. The applicants

were also required to have an eclectic rather than a religious orientation toward helping, exhibit evidence of flexibility, and show evidence of regular attendance at a senior center. Despite the application of these guidelines, however, ill health, too many personal commitments, a religious orientation that precluded openness to learning a different counseling approach, and poor trainability contributed to only five of the original fifteen senior citizens trainees remaining throughout Hoffman's peer counselor training program.

Hoffman (1983) discovered that some older volunteers who had been selected for peer counseling proved to be unable to provide services in a style compatible with the counseling principles of the program. The two reasons found for this incompatibility were an affinity for advice-giving and an inability to accept some client behaviors because of the volunteer's own religious beliefs. Kirkpatrick and Patchner (1987), however, found that the majority of peer counselors were able to be taught to delay advice-giving and could be made aware of the need to accept some behaviors and values with which they might not agree.

In contrast to Hoffman's (1983) premises, Kirkpatrick and Patchner (1987) proposed that elaborate pre-training should be avoided because it might imply that the volunteer is being tested for acceptability. These authors maintained that all those who desired to take the training should be accepted into such a program. Kirkpatrick and Patchner proposed that (a) opportunities available should be matched with volunteers' experience and background, (b) volunteers should be recruited and trained on a group basis so that

the volunteer has a peer group as a point of reference and as a source of identity, and (c) volunteers should be offered a variety of placements in both direct and indirect service capacities. Potential volunteers should not be turned away because they lack social or job skills, as Kirkpatrick and Patchner's experience demonstrated that many of the volunteers who initially appeared to be the least promising, developed within a supportive atmosphere into the best volunteers. Kirkpatrick and Patchner (1987) also found that it was necessary to understand the peer counselors' motives for volunteering their time and energy in order to meet the volunteers' needs in the training process. They found that this reduced frustration, disappointment, and attrition found to be factors that have led to dissolution of other community-based programs.

Many studies in the available literature regarding the use of elderly peer counselors have suffered from attrition problems due to the realities of the identified population. Although Hoffman (1983) took the position that candidates who are more likely to be unsuccessful in such a program should be identified and eliminated, Kirkpatrick and Patchner (1987) emphasized that volunteer loss or turnover became problematic primarily when the peer counselors' needs were unmet. They proposed that almost all elderly volunteers when properly trained, supervised and assigned to appropriate roles, can become satisfactory counselors. The majority of the research supports this view and indicates that most available, willing individuals are able to be trained as successful peer counselors, and

natural selection can usually be expected to occur without regard for cost effectiveness.

Establishment of Training Programs

Prior to implementing a peer counseling program for the elderly, agency staff should be familiar with the particular volunteers' capabilities. Due to the particular needs of the elderly population, France (1989) noted that utilization of peer counselors who were frail and quite elderly presented unique problems; many elderly have poor hearing, sight and mobility (e.g., some use walkers or are wheelchair-bound). France found that training needed to be geared to accommodate these problems, such as the use of a microphone to amplify instruction and large-print training materials. Elderly peer counselors can only be used as long as their health permits, so France proposed that training should be on-going to ensure the availability of an adequate number of peer counselors.

In creating a climate for learning in their training program at Century House in British Columbia, Petty and Cusack (1989) emphasized the importance of physical comfort, emotional support, and the learner's self-concept. They found that if the trainee's self-perception included an inability to learn, his or her performance suffered. Negative thinking about ability to learn needed to be addressed, and cognitive restructuring was often necessary before training was initiated.

Kirkpatrick and Patchner (1987) claimed that many volunteers who had never been in the work force or had been away from it for some time questioned their ability to fulfill the role of volunteer.

These individuals worried about learning what they would need to know in order to be effective counselors, which decreased their capacity to learn new ideas. Because a large proportion of the elderly are female, Kirkpatrick and Patchner also proposed that specific training concerning the counseling of women and women's issues generally was important in training elderly peer counselors.

Of the 26 trainees Petty and Cusack (1989) accepted for a peer counseling program at Century House in British Columbia, 18 seniors completed the 18-month long training. Their model was designed not only to train in counseling skills but to assist participants in taking an active role in developing and maintaining the program. A questionnaire was administered to the training group and to a control group at the beginning and immediately following the training program. Both groups were active participants in programs at the center. The treatment group attended a 50-week peer counselor training program (individual attendance ranged from 28 to 50 sessions).

The questionnaire included a section designed to yield sociodemographic data, two attribute assessment sections (knowledge and attitude), and two skill assessment sections. Petty and Cusack (1989) found from their sample that learning was greater if the material to be learned was personally relevant and meaningful. In teaching helping skills, Petty and Cusack found it important for their training to acknowledge the natural abilities gained from a lifetime experience of helping, that is, confirming such skills as friendliness, warmth, and genuineness before proceeding to

supplement or ask for new learning. Trainees also learned skills (e.g., relaxation, assertiveness, and problem solving) that enhanced their ability to deal more effectively with their own personal life situations.

The older adult trainees in Petty and Cusack's (1989) sample had preconceived notions of the nature of their helping relationship which was very much at odds with the client-centered approach which was offered by the training. Until these ideas were set aside, the trainees had a very difficult time applying new concepts. The habit of giving advice prematurely also proved to be difficult to unlearn in other studies (e.g., France & Gallagher, 1984; Gallagher, 1985).

Petty and Cusack (1989) found that older learners generally needed more time to master a lesson than younger peer counselor trainees, and they needed learning to be scheduled at their own pace. Senior learners were found not to be a homogenous group and individual's learning pace had to be given special consideration. Petty and Cusack allowed trainees to move through the material at their own pace, and moved to the next phase only when the majority of trainees had attained a certain level of expertise.

The same learning principles which were found to be helpful in these programs with the elderly, are likely to be helpful when applied to any population. Future research comparing different age groups and the effectiveness of these particular learning principles would be valuable in determining if there are indeed specific guidelines which differentiate principles helpful to the elderly from those principles

which are generically helpful in the learning process across all populations.

Overall, however, the literature shows that elderly peer counselors demonstrate the ability to learn the requisite skills to become effective counselors if consideration is given to the particular physical limitations of the individuals, and if pacing of material to be learned is slower than in traditional peer counseling programs for younger subjects. Emphasis placed on the positive skills the subjects already possessed proves helpful in reframing the cognitive concepts to be learned, and is also helpful in the effort to dispel the more directive, judgmental or advice-giving approach which some of the seniors needed to overcome.

Community Agencies

Several senior peer counseling programs described in the literature were initiated through community mental health agencies, and the successful initiation, development and maintenance of these programs is discussed throughout this paper. This section, however, presents the results of research from several programs operating from within community mental health centers which demonstrate different aspects of the peer counseling programs which have been shown to be effective. These programs indicate the variety and extent of the use of senior peer counselors by community agency programs, as well as the research that has been done on them. Emphasis is given to the importance of the agency staff's knowledge of the elderly in the development of the peer counseling project and

their continued involvement as a referral network to back up the work of the peer counselors.

The Senior Health and Peer Counseling Center (SHPCC) based in Santa Monica, California began its peer counseling program in 1978. Since that time, 208 counselors have been trained. Each counselor at SHPCC was required to volunteer eight hours per week for one full year after their training was completed. Two of these hours were spent in group supervision which provided an opportunity for the supervisor to (a) maintain close contact with counselors, (b) observe their level of satisfaction, and (c) watch for symptoms of burnout (Bratter & Freeman, 1990).

The SHPCC training model comprised a 12-week, 24-session program that presented a full range of subjects and interventions suited to the aging population served, emphasizing the significance of personal growth (Bratter & Freeman, 1990). Various methods have been used to evaluate the success of the Senior Health and Peer Counseling Center's peer counseling program, and the result has been an accumulation of nonexperimental descriptive data that demonstrates client improvement in several areas (Bratter, 1986).

In order to achieve a broader view of peer-counseling programs, Bratter and Freeman (1990) sent a questionnaire to 80 agencies that had purchased the SHPCC training package. Of the 42 agencies that responded, 19 were conducting peer-counseling programs, and 18 of these were using the SHPCC trainer's guide. From 1983 to 1989, 38 training events were reported. The range in the number of counselors trained at each agency was 4 to 99, with a mean of 33.

Twenty-two percent of the agencies had trained 53 or more counselors. The mean age of the counselors ranged from 49 to 65. Five percent of the agencies reported counselors between the ages of 94 and 98. The mean number of counselors available at each agency was 20, with a maximum of 60 reported (Bratter & Freeman, 1990).

From their survey data, Bratter and Freeman (1990) found that peer counselors were trained to address a broad variety of issues. The most common reasons clients sought counseling were reported to be illness and loss (26%) and emotional difficulties (24%). Half of the agencies reported doing individual counseling, while another 38% used various modalities, including work with groups, families and couples. Counselors saw 44% of the clients at the agency or a senior center, 33% were seen at home, while the others were seen in a variety of settings. Counselors saw 72% of their clients weekly, and 19% were seen two to three times a week or as needed. Although little formal evaluation of the particular SHPCC peer counseling programs operating was available, the most commonly used method of evaluating the effectiveness of counseling was with evaluation forms (24%), through supervision (33%) and through client self-report (14%) (Bratter & Freeman, 1990).

Another elderly peer counseling program operating through a community agency is one directed toward elderly victims of crime and violence. According to Burke and Hayes (1986) and Hayes and Burke (1987), in 1986 violence against elderly persons was increasing, and fear of victimization was often listed as one of the elderly population's greatest fears. Elderly persons are less likely

than their younger counterparts to cope successfully with their reactions to crime. Because of the great potential for victimization of the elderly, many of them become isolates who fear for their safety even in their own homes.

Hayes and Burke (1987) stated that greater vulnerability to criminal victimization may be caused by economic, physical, situational, and psychological factors that set the elderly apart from other age groups. Their fixed and often small income levels make the losses by elderly persons all the more severe. Diminished physical resources leave elderly victims particularly disadvantaged when confronted by attackers.

The Peer Counseling for Older Adults Project (Burke & Hayes, 1986; Hayes & Burke, 1987) was initiated in 1977 in response to local concerns regarding the lack of services in central Illinois for elderly victims of crime. Senior citizen volunteers were recruited through the local media and service organizations to provide needed services for the elderly who lived in their communities. The peer-counseling project was a multilevel intervention that involved older adults directly in their own continuing development through training in the use of basic counseling skills. It used the talents and energies of the elderly as helpers, and trained peer counselors to serve as advocates for other older adults.

Burke and Hayes (1986) reported that the peer-counseling project was actually comprised of two related programs. The first was intended to reduce crime and fear of victimization among the elderly by alerting them to ways in which they might protect

themselves, their homes, and their possessions. Designed to be educational, Operation Senior Security was a crime prevention approach that attempted through the use of films, slide presentations, lectures, and discussions, to alert elderly persons to the existence of potential threats to themselves and their residences. Elderly volunteers were trained by professionals from law enforcement and social service agencies to be knowledgeable about the various elements of the awareness program.

The second program, Operation Victim Support (OVS), was intended to train elderly volunteers to work as peer counselors who could provide assistance to, and support for, elderly victims of crime and violence. According to Burke and Hayes (1986), the program developed in 1979 to train the peer counselors included a total of 30 hours, divided into 10 three-hour modules. Each module was designed to involve the participants in learning about themselves and the helping skills they already possessed, as well as providing opportunities for acquiring new interpersonal skills. Monthly two-hour supervision sessions were held for the peer counselors throughout the year.

During the years following the program's inception, Hayes and Burke (1987) claimed that assistance to victims covered a wide range of situations, from single sessions with victims who felt secure enough to deal with their own victimization to long-term involvement with victims whose complex problems may have required referral to one or more of the community agencies providing services to elderly persons. The volunteers usually worked in pairs, although individual

peer counselors may have assisted victims, depending on the victims' particular needs and situation.

Approximately half of the counselors were still actively involved in working with elderly victims in 1986. Nineteen respondents participated in a formal evaluation of the OVS training program. On a five-point scale, ranging from excellent (5) to poor (1), 14 respondents rated their seminar excellent in terms of its quality as an educational experience and 5 respondents reported their educational experiences to be very good (Mean = 4.8).

According to Hayes and Burke (1987) the usage rate for peer counselor services was also a partial indication of the program's effects on victims served. Since the program began in 1979, OVS counselors received more than 2,000 referrals for criminal or violent acts against individuals who were age 60 or older. Although there were no formal studies conducted on the effects of the programs on the victims, the annual attendance at the community education programs since 1977 showed an average increase of 13%. Also, the number of elderly victims served annually by peer counselors remained steady at an average of 226 cases since reaching high totals of 471 and 311 in 1981 and 1982 respectively. Unsolicited testimonials from victims confirmed the expectation that the peer counselors provided much needed support and information immediately after commission of the crime. Victims reported that they felt less alone, better informed, and increasingly willing to venture back into the community after talking with the peer counselors about how to safeguard themselves and their property.

In 1987, approximately 35 to 45 peer counselors still remained actively involved in both Operation Senior Security and Operation Victim Support. The peer counselors ranged in age from 60 to over 90 years, with the ratio of Whites and Blacks approximately 2:1 (Burke & Hayes, 1986; Hayes & Burke, 1987). Hayes and Burke (1987) indicated that participants varied in educational attainment from one who completed eighth grade to one who had a doctorate. The majority were high school graduates. The women (half of whom were widowed) slightly outnumbered the men (about 18 to 14), and five couples in 1987 worked as teams on victim referrals.

According to Hayes and Burke (1987), experience with the Peer Counseling for Older Adults project demonstrated that peer counselors could make significant contributions to a systematic, community-based prevention program for elderly victims of crime and violence. Hayes and Burke maintained that for mental health counselors who are faced with an ever increasing caseload of elderly clients and continually decreasing financial support, the use of elderly persons as peer counselors may be able to help to offset the balance. Beyond the direct benefits to the victims themselves in terms of reduced anxiety, decreased vulnerability, and increased social mobility, the participants in the programs reported renewed capacity to relate to others (Burke & Hayes, 1986; Hayes & Burke, 1987).

The success of this program has exciting implications but there is still need for more extensive research. Due to longevity and stability in the community there is the possibility of conducting long-term outcome studies ex post facto to demonstrate the program's

effectiveness. It may be possible to research the extended effects of the program by comparing crime victims who received peer counseling in the past to those who did not. This would be a more extensive evaluation of the peer counseling program than has been available to date.

Kirkpatrick and Patchner (1987) also addressed the issue of the use and training of elderly peer counselors in a community agency and the role of the agency in incorporating this mode of service into its operation. They claimed that thinking of the aged as a uniform and homogeneous group with each person having similar capacities can lead to serious mistakes during program development. They also postulated that the first step in the decision to use older persons as peer counselors requires that agency staff in charge of setting up volunteer programs become acquainted with basic knowledge about older people.

Kirkpatrick and Patchner (1987) proposed that the first function of the volunteers is that of an advocate. Because peer counselors often work within the community, they should be well-acquainted with the resources available in that community. They should also be given training in the referral process, particularly in cases that require assistance beyond the peer counselor's capabilities.

Kirkpatrick and Patchner (1987) suggested that an active outreach program could identify problems in early stages of development and thus help to avoid the premature institutionalization of older members of the community. Advocacy was used to help clients become aware of available services, assist them in receiving

needed services, and facilitate the development of skills that were necessary for independent living. The peer counselor acted as a role model so that elderly clients would eventually have the confidence to become their own advocates.

According to Petty and Cusack (1989), the ultimate goal in adult program development and certainly in the development of community support programs for seniors should be to empower the seniors to take an active role in the direction and management of these programs. Kirkpatrick and Patchner (1987) and Bratter and Freeman (1990), however, indicated the importance of the active involvement and support of community agency professionals in providing ongoing input to these programs. Knowing their limitations and being aware of the back-up and referral network available in the community helped individual elderly peer counselors feel much more confident and secure in efforts to help their peers.

The studies presented in this section appear to have been concerned primarily with showing the particular program in question, and what was found to be useful in the program rather than answering research questions for the purpose of the development of future training programs. These program evaluations constitute important preliminary data and raise important research questions. Despite differences in philosophies and presentation, the wide varieties of programs operating through community mental health agencies which used elderly peer counselors demonstrates the variety of modalities and environments in which peer counselors can be successfully utilized.

These studies illustrate the success of such programs as demonstrated by the numbers of individuals they have trained and clients helped. Utilization of these programs by community mental health agencies may be a most effective avenue for outreach and treatment of the elderly population. Continued publication of successful program implementation may encourage more research in this area thus impacting future funding for such programs. Results of further research may impact the efficacy of future models for the training of elderly peer counselors.

Group Programs

Lieberman and Bliwise (1985) stated that nonprofessional help systems postulate that reducing psychological distance promotes identification and trust which in turn facilitate productive therapy. In peer counseling, when the selected helper shares a cultural background or social position with the client, he or she will presumably convey greater understanding of certain problems and will appear less threatening to the person seeking help. Of all help systems, self-help groups achieve the greatest psychological parity between the helper and those being helped. Not only are helpers frequently similar in social background, but more importantly, they often share the same affliction (such as aging) as those seeking help (Lieberman & Bliwise, 1985). The following section presents various different types of nonprofessional, peer-led, group-conducted programs which have been implemented in the community for the benefit of particular populations of the elderly.

Actualization Groups

Lieberman and Bliwise (1985) presented a study of Senior Actualization and Growth Explorations (SAGE) which a group of mental health professionals began in the Berkeley, California area in 1974. It was a group program for the elderly that was designed as a professional treatment system. Originally, all groups had mental health professionals as their leaders. By 1976 however, the demand for groups far exceeded the supply of professionally trained leaders. In response to this demand, the professionals invited SAGE graduates to become group leaders. Encouraged by the professional staff, SAGE evolved into a seniors' self-help organization.

According to Lieberman and Bliwise (1985), the founders derived much of the underlying philosophy and methodology for SAGE from the human potentials movement. Interventions focused primarily on correcting some of the physical disabilities associated with old age and the psychological and social issues relevant in later life. They set as primary goals continued development in the latter part of life and "holistic health." Some of their specific goals included freedom from pain, disability, and emotional confusion, to be achieved through harmony between mind, body, and spirit.

Lieberman and Bliwise (1985) reported that SAGE groups contained 10 to 15 members aged 60 or over who met with two leaders every week for a three- to four-hour session during a nine-month period. The program encouraged members to be supportive of one another, to maintain contacts beyond the formal group setting, and to practice outside their meeting what was learned within the

group. Group meetings centered around meditation, relaxation, guided discussions in groups as well as in pairs, yoga, massage, dream analysis, and exercises designed to enhance physical well-being. The leaders guided the group exercises and clarified group process.

Those chosen to be leaders attended 32 hours of workshops which focused on the setting of group goals, principles of group psychotherapy, and a review of SAGE techniques. Professional staff provided ongoing weekly supervision to peer leaders. Lieberman and Bliwise (1985) did a controlled study in which therapeutic groups led by professionals were compared to those led by peers who shared similar status but who were trained in professional methods.

All SAGE applicants were screened for physical vulnerability and severe psychiatric disorders. Those accepted into the program (over 95%) were randomly assigned to one of six groups, three led by professionals and three led by peer leaders. Thirty applicants were placed on a waiting list which served as a control group. The 86 women and 22 men interviewed formed an unusually well-educated sample of elderly persons; over 75% had continued their education beyond high school. They ranged from 60 to 83 years of age; 40% were between 60-64, 36% between 65-69, and 23% over 70. One-half were married, about one-quarter widowed, and the remaining divorced, with a few who had never married (Lieberman & Bliwise, 1985).

All participants in the groups were interviewed prior to the start of each group, and immediately following termination of the group 9 months later. Lasting from 3 to 4 hours, interview sessions

elicited information about present life circumstances as well as personal goals. Using a tripartite framework to evaluate SAGE, Lieberman and Bliwise (1985) examined the goals of the client and the organization, along with criteria of a mental health perspective.

Lieberman and Bliwise (1985) indicated that in order to index client perspective, participants described their own major goals and objectives at the outset of the program. At the end of the group program each individual rated, on a 9-point scale, the degree to which he or she had accomplished these goals. These series of pre- and post-intervention measures on goal attainment scales and physical and mental health indices were used to evaluate the impact of the SAGE program.

Lieberman and Bliwise (1985) first compared the professionally led, peer-led, and contrasting control group on their pre-group scores. When the pre-group scores were compared between groups, the peer-led group mean was significantly lower (better) than that of both the participants of the professionally led and control groups on a measure indicating the individuals' perceived level of physical health concerns that interfered with their life. The only other significant difference was that of self-esteem, the peer-led group members reporting significantly lower self-esteem than did members of both the professionally led and contrasting control groups. Residualized change scores were used in order to control for these initial differences.

On post-group scores, members of both the professionally-led and the peer-led SAGE groups indicated that they had accomplished

their desired goals to a greater extent than those in the control group. Lieberman and Bliwise (1985) found no significant improvements on any of the measures of physical status or health behavior. Analysis of mental health dimensions yielded small but significant lowering of symptoms and increases in self-esteem associated with participation in the groups.

Reduction in psychiatric symptoms, however, occurred only among members of professionally led groups. Mean symptom levels remained approximately the same before and after group participation for the peer-led members as well as for those in the control group. While overall positive shifts in self-esteem emerged for members in all three conditions, only the increases for members of professionally-led, rather than peer-led groups were significantly greater than those experienced by controls.

The findings of the study clearly suggest that SAGE-type groups led by professionals produce somewhat more positive outcomes than similar groups led by trained elderly. The ideology of SAGE involved abstract notions of growth and development borrowed from the human potentials movement and healing techniques that required a leader and specific training. Perhaps the factor responsible for the differences in the group outcomes is that of building these characteristics of professional treatment models into their help strategy model.

Given that yoga, autogenic healing, dream analysis, and so forth, involved more than the pragmatics of daily living, Lieberman and Bliwise (1985) noted that there is no reason to assume that novices

will be able to teach these methods as successfully as those with years of professional training and practice using the same techniques. It is possible that the peer-led groups would have had a greater impact if the interventions had been less esoteric and aimed more directly at the daily living situations of the members.

According to Lieberman and Bliwise (1985), the real differences in their results may have had little to do with professional expertise and skill, but rather in the status attributed to professionalism. To the extent that such a view of treatment is an important ingredient in facilitating change, they stated that nonprofessionals would never, or rarely, be as effective as professionals. It might be useful to test this hypothesis by conducting another study in which two groups of subjects are assigned to peer counselors, with one of the groups told that they have been assigned to professionals, and the other told they are with peer counselors. It would be interesting to observe whether or not the expectation of the subject about the leadership of the group contributes to the therapeutic nature of the experience.

SAGE is an interesting program in terms of its popularity and success. Lieberman and Bliwise (1985) presented some of the more scientifically rigorous research available on peer-led groups with the elderly in their evaluation of it. Although the professionally-led groups produced more positive outcomes than did their peer-led counterparts, the peer-led groups were overall fairly successful. Members of the peer-led groups did report that they had accomplished desired goals, and they demonstrated some decrease in

mental health symptoms and an increase in self-esteem. The reality is that the members of the peer-led SAGE groups met the goals that they had for themselves. A long-term study, after the leaders had led a series of several groups with continued supervision, may have had less disparate results.

Spouse Support Groups

Rollins, Waterman, and Esmay (1985) presented a case study conducted at Friendship Haven, Inc., in Fort Dodge, Iowa, which observed a peer support network of seniors whose spouses were in nursing home placement. The period of time a resident spent in the facility where the study took place varied from less than six months to as long as six years. Problems from which the ill spouses suffered varied from stroke to Alzheimer's Disease to terminal cancer. The majority of the ill spouses were severely impaired in their ability to communicate or relate to his or her husband or wife.

From December 1, 1982 to May 1, 1983, there were a possible 19 married couples that could participate in the Spouse Support Group. Nine spouses attended the first meeting. The core group consisted of three wives and six husbands. Others attended only once and one husband attended three times until the death of his wife. The ages of the group members ranged from 59 to 85 years of age.

Rollins et al. (1985) indicated that the first meeting was designed for the well spouses to become acquainted with each other and begin building trust within the group. The second meeting included a brain-storming session to determine the purpose and objectives, as well as the boundaries of the Spouse Support Group. At

the third meeting the Staffing Coordinator explained the staff-resident ratio and staffing procedures, answering questions and speaking to the concerns of the spouses. The fourth meeting was led by a clinical psychologist who discussed coping with the stress of long-term illness in the family. At the fifth meeting a nurse from the Hospice presented a program on dealing with losses, death and dying. The chairman of the Care Review Committee presented a program on the role and function of that committee at the sixth meeting. Following each presentation, 30 to 40 minutes were allowed for discussion, questions, sharing of feelings and the experience of shared support. A social time was provided to facilitate group interaction.

Rollins et al. (1985) reported that when the first death in the group occurred, the respective spouse experienced relief as well as mourning after having been under constant stress as the primary caregiver for several years and then as part of the nursing home experience for months. This individual's reaction was validated by the friends and families in the Support Group. The Spouse Support Group offered peer support which relieved some of the feelings of aloneness and provided opportunities to establish new friends and contacts with other families undergoing similar stressors surrounding the nursing home experience.

In addition to finding themselves at a time of increasing personal responsibilities, role changes, and financial pressures normal to their same-aged peers, these particular subjects were also dealing with the loss of support of the most significant relationship in

their lives. These spouses of nursing home residents experienced many of the psychological, physiological and sociological guilt reactions to loss that widows and widowers experience following the death of a spouse. However, the responsibilities of the marriage continued.

According to Rollins et al. (1985), the group improved communication and understanding between the well spouse and the staff. Participants also developed advocacy skills by discussing their concerns as a group, and then by designating formalized meeting times with the staff as a forum for the group's questions and concerns. In the opinion of the authors, the Spouse Support Group validated the unique role of the well spouse in the nursing home setting as compared to the time when the residence was operating without such a network available. No reasons were given for the discontinuation of the program after the designated period of time.

Methodologically this was a very weak study whose scientific value could have been improved with minimal effort by using written surveys with Likert-type scales upon which the members of the support group could indicate their feelings regarding their experience of the support group and the nursing home. Pre- and post-test measures might have been used to indicate any change in the spouse's feelings regarding the nursing home. Use of a control group also could have strengthened the scientific value of this study. Long-term follow up studies would be useful to determine if over time there was a difference in the incidence of complicated bereavement between the two groups. However, the positive case report data from

the participants in the program, and the support that was verbalized cannot be ignored.

Educational Groups

Glanz, Marger, and Meehan (1986) stated that stroke was the third leading cause of death in the United States and was the leading cause of disability. The incidence of stroke increases with age and the long-term survival rates decrease with age. Stroke prevention and treatment are becoming increasingly important as the population of elderly individuals in the United States increases. With older adults living longer, the increased incidence of chronic disease can result in great burdens of disability, dependence and high medical costs.

Glanz et al. (1986) proposed that a reduction in risk factors for stroke, along with the recognition of early warning signs, had the potential to benefit the elderly by helping them avert unnecessary disease and disability, thus improving the quality and length of life. The authors examined outcome and process evaluation of a stroke risk factor education program in a senior citizens' center using elderly peer facilitators. The goals of this program were to increase senior residents' knowledge of stroke risk factors and warning signs, to establish a social support network at the center, to promote healthy behaviors, and to provide skills to reduce stroke risk.

The intervention program had two phases. Glanz et al. (1986) reported that Phase I was a seven-session training program for peer facilitators who were identified as opinion leaders within the senior center. The training program covered content related to strokes,

transient ischemic attacks (TIAs) and risk factors including diet, exercise, stress management and medications, as well as communication skills and the use of health services in the community. Phase II of the program included formal educational sessions for all senior center members (on the same topics) and also involved informal provision of support, information, advice and referral by peer facilitators. There were two "booster sessions" also during this phase to reinforce the peer facilitators' Phase I training. For each phase of the program the researchers developed a set of specific, measurable objectives.

Glanz et al. (1986) conducted both outcome and process evaluations to assess the program experience and its effectiveness. Outcome evaluation assessed (a) knowledge; (b) attitudes; (c) behavioral intent in the peer facilitators and the center population, and (d) the extent to which the peer facilitators provided health information, direct assistance and emotional and moral support to reinforce positive health behaviors and health behavior change. Process evaluation provided information about exactly how the program was carried out, experiences with various components of the program, and qualitative information related to its effectiveness.

In the outcome evaluation knowledge, Glanz et al. (1986) assessed attitudes and behavioral intent using a quasi-experimental design in which pre-tests and post-tests were completed by the peer facilitators, a sample of 67 center members and a control group of 43 seniors from another similar center without a stroke education program. The tests were administered three times to the peer

facilitators and center members—once at the beginning of Phase I, once at the end of Phase I (considered both a post-test for Phase I and a pre-test for Phase II), and again at the end of Phase II.

Glanz et al. (1986) assessed the activity of the peer facilitators in the outcome evaluation using simple weekly logs kept by the peer facilitators for 12 weeks, beginning midway through the training sessions. Data sources for the process evaluation included both qualitative and quantitative records collected during the program. An average of 15 peer facilitators out of the initial total of 17 attended each of the training sessions, with 11 attending all the sessions.

Although there were no significant differences between the pre-test averages of the group scores reflecting knowledge of stroke and stroke risk factors, at post-test I there were highly statistically significant differences between all groups, with peer facilitators scoring highest, followed by the experimental and control groups. That is, the program was most effective for the peer facilitators, but the participants also benefited. This was further demonstrated in that there were statistically significant differences between the peer facilitators and the experimental group at both post-tests.

A set of follow-up questions asking for self-rating of understanding, reported awareness and attitudes about health habit change, self-reported behavior change among peer facilitators, and general reactions to the Peer Facilitator Program, was completed by each group along with the final post-test. Glanz et al. (1986) found no statistically significant differences between experimental and control centers in self-rated knowledge and interest about health, or

perceived ability to change health habits. However, the objective pre-tests and post-tests indicated that those who had been in the program gained more knowledge than those who had not been in a program. One of the most noteworthy aspects of this program was that it ultimately reached large numbers of people in the community with a very modest investment of money and professional staff time. Glanz et al. (1986) found that peer facilitators reported speaking to a total of 2,674 people over the 12 weeks, or an average of 17.6 people per peer facilitator per week.

Future studies would benefit from larger samples and a longer follow-up period to examine retention of learning, continuation of peer educator activities and health behavior and health status change, as this study did not demonstrate that there was any evidence that strokes or transient ischemic attacks were actually prevented. The study had other methodological weaknesses which were imposed by a real-world setting such as the lack of random assignment to experimental and control groups. "Opinion leaders" were assigned to be the peer facilitators rather than using random assignment. Efforts were made to encourage the same individuals who completed the pre-tests to fill out the post-test forms in the experimental and control center groups, but this was not always possible. Therefore, the repeated tests in experimental and control groups actually represent repeated cross-section samples of these populations.

Overall, however, Glanz et al. (1986) found that peer educators were both a credible source of information and served as role models for health-enhancing behaviors. Findings from both outcome and

process evaluations indicated that the Peer Facilitator Program was successful in meeting its stated objectives of training elderly lay individuals to carry out stroke prevention education, increasing the knowledge of both the peer facilitators and other seniors at the program center, and disseminating information which covered a broad range of topics about stroke and stroke risk factor reduction.

The successful use of elderly peer counselors in group settings is demonstrated to have been very successful by the studies reviewed above. In the group modality individuals can learn that they are not alone in their experience of aging or grieving. The various goals and needs of different sub-groups of the elderly population can be met through the use of peer counselors with the proper training over time. The strength of the peer counseling programs may indeed lie in their ability to identify with the same people whom they were helping.

Individual Programs

Just as elderly volunteers counsel others in group settings, there is research which supports the use of peer counselors helping others on a one-to-one basis. The following section reviews the research that has been conducted on peer counselor programs in a variety of settings that train the elderly on an individual basis as advocates for their peers.

Nursing Homes

Older people may become withdrawn when they leave familiar surroundings and enter a medium- or long-term care residence.

Scharlach's (1988) research indicated that peer counseling programs have been particularly beneficial in helping older persons adjust to nursing home admission by providing new residents with needed information regarding their unfamiliar and often distressing surroundings, while serving as an important source of social and emotional support. Scharlach maintained that such information and support have been shown to ameliorate the potential stress of nursing home placement and may thereby alleviate the disorientation, disaffiliation, and hopelessness often experienced during the initial weeks of nursing home residence.

In Scharlach's study (1988) peer counselors were resident council members of a large, proprietary nursing home who responded to an announcement regarding the creation of a welcoming committee. Their mean age was 84.4. These older adults, although among the most socially well-functioning residents, had been diagnosed as having a variety of serious disabilities, and the majority were unable to ambulate independently.

Of the 30 residents who volunteered to participate in Scharlach's (1988) study, only 15 were interested in undergoing the peer counseling training. It was decided, therefore, to allow the other 15 individuals to serve as a comparison group. Three peer counselors and one member of the comparison group were hospitalized during the study period, leaving a final sample of 11 peer counselors and 14 comparison residents.

Comparisons between the peer counselors and the comparison group revealed no significant differences in age, medical diagnoses,

pre-treatment ratings of social adjustment, pre-treatment physical functioning or pre-treatment appearance ratings. Prior to the start of training and again four weeks following its completion, Scharlach (1988) had the appearance of the volunteer counselors assessed by a staff member, who was blind to the conditions and purposes of the study. The appearance of the 25 volunteers was rated on a five-point Guttmann scale, which ranged from "resident is extremely disheveled and unkempt" (1) to "resident is clean and well-groomed in every way" (5). Post-treatment appearance ratings were compared with pre-treatment ratings.

The peer counselor trainees in Scharlach's (1988) study attended weekly one-hour training sessions for a period of eight weeks. After the fourth week of training, the peer counseling portion of the study began. Fifteen persons in all, representing every second admission to the facility during a two month period, were selected to receive the peer counseling, whereas the other 15 new admissions during that period received no special attention and served as controls. Because of differential attrition due to death or discharge, the final sample consisted of 14 participants in the treatment group and only 9 in the control group.

At admission and again two months later, the social adjustment and physical functioning of the newly admitted residents were assessed by an occupational therapist, who was blind to the conditions and purposes of the study. According to Scharlach (1988), social adjustment was measured using the Nurses' Observation Scale for Inpatient Evaluation (NOSIE-30), a 30-item behavior rating scale

that is scored for six factors: Social Competence, Social Retardation, Social Interest, Personal Neatness, Irritability, and Manifest Psychosis. Physical functioning was measured using the Lawton-Brody Physical Activities of Daily Living Scale. The Physical ADL Scale is used to assess the level of functional ability (from 1 = requires total assistance to 3 = requires no assistance) in each of seven areas of physical self-care: (a) ambulation, (b) transfer, (c) dressing, (d) grooming, (e) eating, (f) bathing, and (g) toileting.

Scharlach (1988) stated that the prospective counselee was visited by a peer counselor within the first three days of admission to the nursing home. The peer counselor introduced himself or herself to the new resident, gave the newcomer the "New Resident Information Sheet" and attempted to initiate casual conversation. If the new resident was agreeable, the visitor would provide orienting information about the facility and discuss what to expect from staff and other residents and how to cope with some of the discomforting aspects of institutional life. For newcomers whose mental or physical impairments made such interactions impossible, visitors were asked to simply make nonverbal contact with the person, perhaps by holding their hand.

Participants' scores at the time of admission on the six subscales of the Nurses' Observation Scale for Inpatient Evaluation and on the Lawton-Brody Physical Activies of Daily Living Scale were compared with their scores two months later. Scharlach (1988) found that social competence increased for 79% of the new residents who had received peer counseling, but for only 17% of those in the

control condition; it decreased for 14% of the counseling recipients and 67% of the control participants. Social retardation decreased for 43% of the counseling recipients and 33% of the control participants; it increased for 36% of the counseling recipients and 67% of the control participants. There were no significant differences between the two groups with regard to any of the other measures of social adjustment or physical functioning.

Appearance ratings of the peer counselors showed improvement for 33% of the experimental sample, stayed the same for 58% and deteriorated for 8%, whereas ratings of the comparison residents revealed that 50% stayed the same and 50% deteriorated. Scharlach (1988) maintained that the improved social functioning of the new residents may be attributable to the support and personal attention provided by their peer counselor. Not only did newcomers receive emotional support founded on peer counseling skills, but they also obtained concrete information concerning their new environment and the community's expectations of them in the process. Scharlach suggested that the peer counselors also may have served as models from which new residents could derive information about standards for situationally-appropriate behavior in the nursing home setting.

The generalizability of the findings of this study may be limited by the non-random selection of peer counselors, the investigator's participation in the peer counseling training sessions, and the high rates of discharge and death among the new residents who did not receive peer counseling. The degree of impairment among the

residents also played an important factor, as many of the newcomers who were supposed to serve as counselees were too severely impaired to interact in a meaningful manner with a visitor. Some of the peer counselor trainees were so socially impaired that they could not participate appropriately in the group training sessions or master the basic peer counseling techniques. However, the results are interesting in that they hint at the potential benefits of peer counselor programs even among a population severely impaired by age.

France (1989) reported that the goal of a project at Oak Bay Lodge, a long term care facility for the elderly in Victoria, British Columbia, was to put in place a group of trained elderly to extend the helping service at the facility. The program was designed to use peer counselors to assist in the orientation of newly admitted residents and to be a model for older people who are not active. Three men and three women were selected for the training program ranging in age from 69 to 96. Prior to beginning training, an evaluation of each member's counseling skills was carried out in order to have a baseline to measure whether there was any improvement over the course of their training.

France and Gallagher's (1984) training program consisted of 11 one-hour modules that focused on skill development and specific issues facing residents at the lodge. Each module of this training program included the presentation of the skill, the modeling of the skill, practice of the skill, and homework. There were four interrelated phases: (a) communication skills; (b) common age-

related life crises; (c) ethics, confidentiality, and referrals; and (d) a practicum.

During a 10-week period, France and Gallagher (1984) continued meeting weekly with the peer counselors to monitor their progress. For each of six trainees, a tape recorded interview with a trained role player was conducted both before and after the peer counseling training. The subjects also responded in writing to eight brief case studies which depicted seniors experiencing stress.

Expert judges rated the empathy levels of both the written and verbal interviews, using Carkhuff's (1969) Empathy Rating Scale and the Hill (1978) response category system. From these measures, France and Gallagher (1984) calculated differences in before and after ratings for each subject. France and Gallagher (1984) and Gallagher (1985) claimed that statistical tests at a .01 level of significance showed that there had been improvement in the trainees' use of empathy. One year following the training, only one of the original trainees had ceased to function in a helper role due to serious illness.

It is not clear from this study how much of any change which may have occurred was actually related to the peer counseling course itself. Merely being a member of a therapeutic group can itself increase an individual's sensitivity, awareness and empathy toward others. The size of this group was very small and it would be valuable to repeat these measures with a larger sample and with a control group.

France and Gallagher (1984) stated that the need for and the effects of a program such as peer counseling with the elderly are

difficult to substantiate in a scientific way, but they nevertheless approached their project with a view toward monitoring various pre-training, training and post-training factors. The authors basically presented the paradigm and philosophy of the program followed by anecdotal information from the peer counselors who had completed the training course.

Individuals in nursing home placement have special needs which can be addressed by other individuals having the same experience. The observational data presented here seem to support the claim that the elderly individuals responded positively to being listened to by another in the nursing home settings. Many of the comments expressed by the resident counselors in the nursing home studies were positive responses about feeling useful and worthwhile in being given the privilege of working as a volunteer and aiding others.

Senior Blind Program

In the Senior Blind Program in Saginaw, Michigan presented by Byers-Lang (1984), peer counselors were defined as legally blind persons over the age of 55 who had expressed a desire to help others and had successfully completed training and a practicum. Peer-counselor training included 20 hours of classroom instruction divided into ten sessions. Homework assignments, mobility evaluations, ten hours of afterclass follow-up, and a two-month practicum provided peer helpers with a balanced background.

The core group of counselors was composed of two males and four females. Peer counselors were matched with clients on the basis

of age, sex, degree of visual impairment, secondary handicapping conditions, geographic location, and interests in recreational and social activities. Byers-Lang (1984) indicated that of these factors, age, sex, and degree of visual impairment appeared to be the most significant agents in a successful pairing.

In conjunction with the rehabilitation teacher, the peer counselors were able to help clients orient themselves to their potential and possibilities after becoming blind. According to Byers-Lang's (1984) case report data, the clients with peer counselors assigned to them made progress toward their selected rehabilitation goals and exhibited increased coping abilities and adjustment to blindness in most cases at a quicker rate than those who did not have a peer counselor. Although no formal measures were used, secondary gains from the training which were observed showed that each participant exhibited improved ability to handle frustration associated with disability, an increased level of self-esteem, and improved ability to function independently.

Byers-Lang (1984) claimed that clients with peer counselors became more familiar with the concept of rehabilitation and services available in the community and began requesting training more often than clients on the usual rehabilitation track. It was the responsibility of the peer helpers to provide clients with additional information on the availability of comprehensive community resources and program activities and to make referrals to the rehabilitation professional regarding the client's interest. According to Byers-Lang it appeared that peer counselors were viewed as role models, assisting elderly

blind clients in rebuilding a network of contacts linking them back into the community at large. Rehabilitation teachers and counselors managing these cases spent less time counseling and explaining how the system functions and instead concentrated on teaching adaptive skills requested by the client or making referrals to other agencies for specialized support needs.

Potential research projects might be to survey the clients of these counselors and obtain some empirical data regarding their adjustment over time, comparing it to the legally blind elderly persons who did not follow-up with this program. Scientific evidence of the program's value substantiated by more structured research could positively impact funding for this and similar programs. The description and presentation of this program by Byers-Lang (1984) indicated that this program has been a very valuable resource to the elderly blind in the community.

Telephone Hotline

Losee, Auerbach, and Parham (1988) evaluated the effectiveness of a crisis hotline in Richmond, Virginia which was designed to provide immediate aid and to serve as an entry point for elderly persons into the community mental health system. They presented data on the overall program impact and on the relationship between volunteer performance and caller outcome. To measure "Technical Effectiveness," a nine-point procedural checklist rated volunteer compliance with certain tasks, including obtaining the caller's name and telephone number, examination of resources available to the caller, identification of specific caller problems, formulation of a

structured plan of action, and determination of suicide potential. One of three measures collectively referred to as the Clinical Effectiveness Scales, rated the degree to which hotline counselors communicated, implicitly or explicitly, their unconditional positive regard for the caller.

Program evaluation in this study involved (a) assessment of overall program impact, (b) assessment of the effects of a training program designed to enhance the technical and clinical skills of elderly volunteers, and (c) assessment of the relationship between volunteer Technical Effectiveness and Clinical Effectiveness and measures of caller outcome. Because of ethical restrictions on taping or monitoring calls, post-training Technical Effectiveness and Clinical Effectiveness measures obtained on a simulated call were used by Losee et al. (1988) to estimate subsequent volunteer performance differences during actual calls. For the same reason, in evaluating outcome the researchers relied upon follow-up data which were obtained from callers, evaluating both objective aspects of the usefulness of the contact as well as more subjective impressions of the helpfulness of the call.

Losee et al. (1988) studied two separate sets of participants, hotline volunteers and hotline callers. Ten female volunteers who ranged in age from 55 to 77 years (Mean = 67.8 years) were recruited for this project. Five of the volunteers were African-American and five were Caucasian; three were married, six widowed and one divorced. Two volunteers had a high school education, five had had

undergraduate or professional training, and three had attended graduate school.

Five of the volunteers completed training and actually worked for the hotline in the Losee et al. (1988) study. Completers did not differ significantly from noncompleters on pretest measures of Technical Effectiveness or Clinical Effectiveness or on demographic characteristics. The 153 callers utilizing this service during the six-month period of evaluation represented a broad range of the elderly population in the Richmond, Virginia metropolitan area.

Losee et al. (1988) evaluated the performance of the hotline volunteers by audiotaping their responses to a single standardized simulated hotline call. A predetermined range of caller problems and responses was available to be uncovered and resolved through the volunteer's efforts. Volunteers responded to the simulated hotline call both before and after training. Volunteers' pre- and post-training performance was rated by means of the Technical Effectiveness Scale and the Facilitative Warmth Scale. Trained raters who were blind as to whether the response of the volunteer was pre- or post-training scored the call in terms of Facilitative Warmth.

Losee et al. (1988) measured caller outcome and service effectiveness during the six-month evaluation period with the Outcome Evaluation Form and the Self-Report Evaluation Form. These data were obtained from the original callers by telephone two weeks after the call. The Outcome Evaluation Form involved the collection of descriptive data from the caller (caller's name, age, sex, the time of day), Problem Resolution, Source of Help, and Referral

Disposition. Problem Resolution (resolved, ameliorated, awaiting disposition, unchanged), Source of Help (call addressed problem, referral addressed problem, help received elsewhere, help not available), and Referral Disposition (completed, attempted, deferred, will not use) were rated on a four-point Likert-type scale and constituted the objective outcome measure.

Losee et al. (1988) had callers rate their level of distress both at the time of the hotline call and at follow-up. Also rated were the degree to which they perceived their problem as being difficult to solve on both occasions, the degree to which they perceived the call as helpful, whether they would consider using the hotline again should the need arise, and whether they would recommend the hotline to other people in need of help. Responses to this form constituted the subjective outcome measure.

The five volunteers who successfully completed the training took an average of 26.2 calls each. According to Losee et al. (1988) the objective data obtained on the Outcome Evaluation Form at two-week follow-up indicated that a significant proportion of the callers received needed assistance through this service. Thirty-six of the 70 (51.4%) evaluated in-coming callers said at follow-up that their problem had been successfully resolved, 13 (18.6%) found it ameliorated, and 14 (20%) were awaiting its disposition, whereas only 7 (10%) stated their problem had remained unchanged. Forty-two (60%) of these callers said that the referral suggested by the volunteer addressed the problem, and 11 (15.7%) stated that the calls themselves were a primary source of help.

Losee et al. (1988) obtained similar findings on the more subjective Self-Report Evaluation Form. Evaluation of perceived difficulty of solving their problem at follow-up versus at the time of their crisis call indicated that 34 of the 58 (58.6%) callers completing this item reported that their problem appeared less difficult at follow-up, 21 (36.2%) reported no change, and 3 (5.2%) found their problem more difficult. Regarding perceived helpfulness of the hotline contact, 25 of the 65 (38.5%) callers responding to this item found the call very useful to them, 18 (23%) rated it as moderately helpful 19 (29.2%) rated it as slightly helpful and 2 (37%) stated that it made no difference. The majority of callers (83%) stated that they would definitely reuse the hotline and 90% stated that they would definitely recommend it to others in need.

Other studies (e.g., Bratter & Freeman, 1990; Lieberman & Bliwise, 1985) in this review have theorized that clients readily identify with peers whom they perceive as sharing their values and experiences, and therefore it is hypothesized that peers will be effective counselors, especially in crisis situations. In contrast to this Losee at al. (1988) suggested that it remains a rarely tested empirical question whether in fact peers are more effective than non-peers in any kind of peer-counseling program. They point out that this is a particularly important question to address, especially when dealing with the elderly.

Losee et al. (1988) maintained that if some younger counselors are shown to be as effective as aged peers, and a pool of both older and younger trained volunteers could be established, the task of

developing and maintaining a service such as the Richmond Senior Hotline might be accomplished much more efficiently, avoiding the significant attrition concerns which occurred in this study due to the realities of aging. Some of the counselors experienced physical discomfort from sitting at the hotline for prolonged periods of time and thus found the hotline work very tedious.

For various reasons only 70 calls out of the total 153 calls which were made to the hotline produced follow-up data. The 83 callers who were reluctant to cooperate with the follow-up call two weeks later, who preferred to remain anonymous and did not leave their telephone number, who could not be reached, or who denied having made the call, may have had a negative reaction, and these data were not calculated into the statistics regarding caller satisfaction or dissatisfaction, thereby skewing the results. At some point this very ambitious and rigorous study could benefit from replication with larger numbers of volunteers. Losee and her colleagues may want to test their hypothesis and have a younger comparison group go through the same training and evaluation to see if the younger counselors may be effective with the older callers. It might also be beneficial to see if the hotline was repeatedly used by satisfied callers over time.

Perhaps with closer examination, and resulting modifications to the program to meet the individual volunteers' needs, the elderly peers would have been happier and thus more content to remain with the program and perhaps become even more successful hotline counselors. De Rosenroll (1989) addressed the same concerns that

Losee et al. (1988) had in working with the elderly population, when he commented on the difficulties of doing research with senior citizens and the dilemmas involved in evaluating peer counseling programs. For example, de Rosenroll suggested that an elderly individual may have short-term memory problems. Individual differences need to be controlled for through selection or matching in order to legitimately assess a peer counseling training program.

The research presented here demonstrates the wide variety of ways in which elderly peer counseling programs have been implemented in reaching the needs of the elderly on an individual basis. Special needs such as blindness, and lower functioning older adults such as those in nursing placement may indicate situations that call for a one-on-one approach in order to better serve the individual's needs. The telephone hotline offers a unique individual method of outreach to meet the needs of the elderly population.

The challenges of completing methodologically sound research with this population were discussed in both the nursing home studies and the telephone hotline study, and attrition continued to be an obstacle in obtaining empirical data. Case reports from individuals illustrate the valuable service that these programs provided, and the special bond that formed between the counselor and the counselee in the individual mode of treatment over time.

Benefits to the Peer Counselors

The literature indicates overwhelmingly that not only did the senior counselees benefit from the counseling process, but also the

peer counselors themselves benefited from having been involved in the helping process (Gatz, Hileman, & Amaral, 1984). Peer counseling offered the counselors structure for their daily lives and an escape from busywork frequently associated with volunteer experiences by older persons. Counselors gained a sense of purpose in their new roles and a chance for personal growth. They also made new friends and developed links with their communities (Bratter, 1986; Gallagher, 1985).

France (1989) proposed that the research reflects the idea that the healthiest way to age is to maintain a high level of activity for as long as possible. According to case reports, elderly counselor trainees appeared to exhibit an increase in self-esteem and in their ability to function independently. Peer helpers appeared to have an increased sense of worth as a result of exercising altruistic desires in being helpful to others (Bratter, 1986; Byers-Lang, 1984; Gallagher, 1985). France (1989) maintained that peer counseling can be a method of empowering residents and giving them greater control over their lives.

Anecdotal reports from staff members in Scharlach's (1988) study suggested that the peer counselor trainees benefited from their experience in several areas of social functioning, including increased assertiveness and social competence. Six participants in his peer counseling trainee program, who had previously been perceived by the nursing staff as withdrawn and frequently inappropriate in their interpersonal interactions, were seen after training as more alert, interested, and socially responsive. These patient counselor trainees

were more willing to spontaneously approach other residents and less likely than before to withdraw when rebuffed. Scharlach maintained that the benefit that peer counselor trainees received from their participation may have been related to the attention and mutual support of the training experience, as well as the opportunity to occupy a clearly defined, status-conferring role within the potentially depersonalizing nursing home environment.

The benefits the subjects in Petty and Cusack's (1989) study believed they received from participation in the training program were improvement of listening skills and general improved communication. There were additional personal benefits that were not anticipated such as increased confidence in abilities, increased tolerance of others, increased ability to make changes in their own lives, and a new focus for time and energies. The treatment group trainees showed a marked increase in helping skills and a greater than 100% increase in skill in compensating for sensory losses. The treatment group also exhibited reduced denial of the effects of aging and reduced anxiety about aging, while the control group showed an increase in anxiety about aging

In Hyde's (1988) training program experiment at the Oak Creek Retirement Campus in Lewisville, Texas, results indicated that after respondents were trained in the use of helping communication skills, their perception of their own helpfulness increased. Approximately 18 residents of the Oak Creek Retirement Campus attended a facilitative communication skills workshop. All participants were healthy, alert, elderly persons, aged between 60

and 90, who lived self-sufficiently (except for one shared daily meal) in apartment units on the campus grounds. The workshop consisted of six weekly sessions of one and one-half hours each. The focus was other-oriented, and empathic communication skills and sessions included both discussion and role-play.

A three-part questionnaire was administered to 20 participants in Hyde's (1988) study during the first and second sessions of the workshop (several trainees joined the workshop at session two) and again administered to 13 participants during the final session. In all, 12 participants took both pretest and posttest questionnaires. The participants, 11 women and 1 man, attended at least five of the six workshop sessions.

Hyde's (1988) results indicated that reported self perceptions of helpfulness increased significantly ($p < .05$). Regarding the ability to discriminate helpful from unhelpful responses, the difference between pretest and posttest approached significance ($p < .10$). This enhanced perception of potential helpfulness can be viewed as a decrease in communication apprehension, and may be a motivational factor in participants' willingness to communicate supportively with others in the community.

A limitation of Hyde's (1988) study, beside the small number of participants, is that Hyde assumed (and it remained untested) that self-perceptions of helpfulness and being able to discriminate different levels of helpfulness can be translated into behaviors. As a further test of the workshop's effectiveness, a measure of the perceived level of helpfulness and supportiveness within the

community could be devised and administered to all members of the community. The relationship between perceived supportiveness levels and actual levels of community well-being thus could be investigated. Hyde's study could be improved upon if the sample were increased in size and if a control group were implemented.

Byrd (1984) conducted a study of the attitude changes of peer counselors and the effect the training program and being an advocate for their peers had on the students themselves. Thirty-eight older adult peer counselor students participated in this study. These individuals were the members of three separate peer counselor training classes that were conducted at a local senior citizens' center. In addition, two other groups of older adults were utilized as control groups.

One group of 26 individuals, called volunteer controls, consisted of older adults who had inquired about adult education classes at the senior center and who, upon being informed about the peer counselor training program, expressed an interest in taking the course. A second control group, which consisted of 33 older adults, was composed of those who had similarly inquired about adult education courses but were not interested in peer counselor training. These individuals comprised the nonvolunteer control group (Byrd, 1984).

The participants in Byrd's (1984) study were given three different types of measures in order to determine the amount of change or personal growth experienced over the duration of the peer counselor course. Palmore's (1977) Facts on Aging Test was

employed to assess the older adults' amount of objective knowledge about the aging process. This instrument was also used to determine the degree of change in knowledge about the aging process that was experienced by the peer counselor students. Additionally, Neugarten, Havighurst, and Tobin's (1961) Life Satisfaction Index and Lawton's (1975) Philadelphia Geriatric Center Morale Scale were used to assess the older adults' attitudes toward and degree of satisfaction with their own lives. Wessman and Ricks' (1965) 16-item Personal Feeling Scale was used to examine the degree of change in the older adults' moods and attitudes over the training course.

Byrd (1984) administered the test battery to the peer counselor students at the beginning and end of the nine-week training course. The individuals in the two control groups were administered the test battery as part of an effort to assess the needs of older adults who were interested in continuing education courses. They were also retested after a nine week interval.

Byrd (1984) found that while the peer counselor students did not significantly differ from the other groups on their pretest scores on the Facts of Aging Test, they did show an increase in the amount of objective knowledge about the aging process as indicated by an increase in the posttest scores. Additionally, Byrd found that while there was no manifest change in morale levels in any of the groups over the course of the study, it was shown that both the peer counselor students and the volunteer controls displayed significantly higher scores on the Philidelphia Geriatric Center Morale Scale, specifically in the Attitude Towards Own Aging and the Lonely

Dissatisfaction subscales of the measure. Not only did the peer counselors gain a better objective appreciation of the various aspects of the aging process, they also manifested significant changes in their feelings toward themselves as well as in their attitudes regarding the training group experience.

Byrd's (1984) analyses showed that the peer counselor students and the volunteer controls differed significantly from their nonvolunteer counterparts on the enthusiasm for life, love, tranquility, self-confidence, and happiness measures of the Personal Feeling Scales. The results of this series of analyses demonstrate that the peer counselor training program attracted a group of older adults distinct from the other older individuals who were interested in continuing education classes. The same series of analyses revealed significant differences between the pre- and posttest mean scores of the peer counselor students on the enthusiasm for life, personal freedom, goodwill to others, social interactions, present work, and self-confidence measures of the Personal Feeling Scales. However, this series of analyses failed to detect similar changes in the pre- and posttest mean scores of either the volunteer or nonvolunteer control groups, thus indicating that the change manifested by the peer counselor students in the above measures may be attributed to the dynamics of the training course (Byrd, 1984).

Byrd (1984) maintained that the pattern of results described above indicates that there was a difference between those older adults who displayed an interest in peer counselor training and those that did not, even before any training took place. The peer counselor

students and the individuals in the volunteer control group seemed more self-assured and secure in the ability to deal with the psychological issues of senescence that formed the basis for the course. The individuals who were attracted to the course also seemed more confident in their abilty to deal with these issues within the group format of the training course.

Byrd (1984) reported that the peer counselor students exhibited an increase in their levels of genuineness or open and honest levels of communication regarding the group aspect of the course. The students also displayed more positive attitudes toward their work and the degree of personal freedom in their lives. Byrd therefore concluded that the effects of the training course were in having assisted the participants in being more open and outgoing with their personal feelings while at the same time instilling positive attitudes about peer counselor work and the students' ability to perform it effectively.

Petty and Cusack (1989) believed that the growth of community peer counseling programs was an opportunity for adult educators, for in addition to having developed counseling skills they made a significant impact on the lives of older adults. Through peer counseling, Bratter and Freeman (1990) claimed older people learned to view themselves as worthwhile, valuable citizens and were more likely to be healthier both mentally and physically. Older people were able to learn that many of the images of aging were myths or stereotypes, that they had options, and that, as a group, they could have power.

Summary and Critique

Haber (1982) proposed that if professionals are to develop a body of scientific knowledge relative to the effects of training programs on older participants and the persons they serve, more programs and better trained personnel are required. There is certainly a need for adequate programming and funding for the aging as the percentage of elderly persons in the population continues to grow. Research which addresses the identification of the particular factors involved in the selection and training of the elderly to be effective counselors, such as the work of Hoffman (1983), Kirkpatrick and Patchner (1987), and Petty and Cusack (1989), would be beneficial in order to make adequate modifications to existing programs.

While much has been written in this review about the value of peer counseling for the counselors as well as for their clients, there is still a paucity of empirical outcome evaluation. There is an absence of objective long-term evaluation measures in many of the different areas where elderly peer counselors have been utilized. Clearly, more research will have direct implications for effective teaching techniques for the older learner, and the research may also impact mental health services available to this portion of the population.

While there is not a great deal of formal evaluation of senior peer-counseling programs, there is a seemingly limitless supply of "heart-warming stories," case studies, and anecdotal information illustrating how peer counseling among the elderly might be able to bridge the current need of this population that is not currently being

satisfactorily served by traditional resources. One reason for the lack of research on this topic may be that many peer counseling programs began in an informal manner, serving obvious needs rather than focusing on research data. The dearth of research in this area might also be a reflection of societal norms in the United States. Research is costly; perhaps the lack of funding available for research in this area reflects the lower level of importance assigned the elderly in our youth-oriented society.

A number of the studies have shown that more and better peer counseling programs for the elderly are required to satisfy the ever increasing needs that professionals cannot meet because of financial constraints. The reality of the current economic situation is that with ever-increasing budget cuts which reduce services available from professionally trained staff, the utilization of volunteer elderly peer counselors in the rehabilitation process offers professionals an opportunity to maintain or enhance current levels of coverage.

A number of the studies noted in this review indicated that the programs presented were faced tenuously with extinction due to lack of funding. As some of the studies are already several years old, economic trends since their publication indicate that there is currently a worsening of financial hardship both for these programs' existence and for the elderly population in general. Peer counseling programs make even more sense in light of this trend, but more scientific data is needed to demonstrate the effectiveness of these programs and to validate their legitimacy, in order to better impact funding. Unfortunately, the current research is admittedly weak in

in respect to methodology. Research which compares the cost effectiveness of the implementation of peer counseling programs compared with implications of individuals receiving no treatment or other forms of treatment might be particularly valuable in promoting the utilization of these programs.

Overwhelmingly in the research presented, older participants were found to be competent trainees, effective workers, and likely candidates to help improve self-esteem in the elderly population. Senior citizen counselors themselves benefited from increased self-esteem because of being found useful, being active, and gaining a sense of purpose within their social network. Counselees' specific emotional needs were addressed and met with supportive listeners through peer counseling programs and the extension of community resources through these programs. Elderly individuals learned that they were not alone in their problems, and that by seeking help from their peers rather than from professionals in a formal mental health atmosphere they did not have to experience any stigma from being pathologized. Programs in a wide variety of settings which address a variety of issues related to aging and life in general, have been implemented with great success, and at minimal cost to the individuals. This indicates that the use of elderly peer counselors should be considered a viable addition to treatment and support in the elderly population.

REFERENCES

Bratter, B. (1986). Peer counseling for older adults. Generations, 10(3), 49-50.

Bratter, B., & Freeman, E. (1990). The maturing of peer counseling. Generations, 14(1), 49-52.

Burke, M. J., & Hayes, R. L. (1986). Peer counseling for elderly victims of crime and violence. Journal for Specialists in Group Work, 11, 107-113.

Byers-Lang, R. E. (1984). Peer counselors, network builders for elderly persons. Journal of Visual Impairment & Blindness, 78, 193-197.

Byrd, M. (1984). Personal growth aspects of peer counselor training for older adults. Educational Gerontology, 10, 369-385.

de Rosenroll, D. (1989). A practitioner's guide to peer counselling research issues and dilemmas. Canadian Journal of Counselling, 23, 75-91.

France, M. H. (1989). Residents as helpers: Peer counselling in a long term care facility. Canadian Journal of Counselling, 23(1), 113-119.

France, M. H., & Gallagher, E. M. (1984). Peer counselling: An outreach program in a home for the aged. Canadian Counsellor, 18, 174-179.

France, M. H., & McDowell, C. (1982). Seniors helping seniors: A model of peer counselling for the aged. Canada's Mental Health, 30(3), 13-15.

Gallagher, E. M. (1985). Capitalize on elder strengths. Journal of Gerontological Nursing, 11(6), 13-17.

Gatz, M., Hileman, C., & Amaral, P. (1984). Older adult paraprofessionals: Working with and in behalf of older adults. Journal of Community Psychology, 12, 347-358.

Glanz, K., Marger, S. M., & Meehan, E. F. (1986). Evaluation of a peer educator stroke education program for the elderly. Health Education Research, 1, 121-130.

Haber, D. (1982). New directions for education and training in gerontology. Educational Gerontology, 8, 251-257.

Hayes, R. L., & Burke, M. J. (1987). Community-based prevention for elderly victims of crime and violence. Journal of Mental Health Counseling, 9, 210-219.

Hill, C. E. (1978). Development of a counselor verbal response category system. Journal of Counseling Psychology, 25, 461-468.

Hoffman, S. B. (1983). Peer counselor training with the elderly. The Gerontologist, 23, 358-360.

Hyde, R. B. (1988). Facilitative communication skills training: Social support for elderly people. The Gerontologist, 28, 418-420.

Kirkpatrick, R. V., & Patchner, M. A. (1987). The utilization of peer counselors for the provision of mental health services to the aged. Clinical Gerontologist, 6(4), 3-14.

Lieberman, M. A., & Bliwise, N. G. (1985). Comparisons among peer and professionally directed groups for the elderly: Implications for the development of self-help groups. International Journal of Group Psychotherapy, 35, 155-175.

Losee, N., Auerbach, S. M., & Parham, I. (1988). Effectiveness of a peer counselor hotline for the elderly. Journal of Community Psychology, 16, 428-436.

Petty, B. J., & Cusack, S. A. (1989). Assessing the impact of a seniors' peer counseling program. Educational Gerontology, 15, 49-64.

Riessman, F. (1990). Restructuring help: A human services paradigm for the 1990's. American Journal of Community Psychology, 18, 221-230.

Rollins, D., Waterman, D., & Esmay, D. (1985). Married widowhood. Activities, Adaptation and Aging, 7, 67-71.

Sargent, S. S. (1982). Therapy and self-actualization in the later years via nontraditional approaches. Psychotherapy: Theory, Research and Practice, 19, 522-531.

Scharlach, A. E. (1988). Peer counselor training for nursing home residents. Gerontologist, 28, 499-502.

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